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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08367

CERTIFICATE OF DEATH

08369
Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>LEE</u> Middle <u>ANTHONY</u> Last		4. DATE OF DEATH <u>AUG</u> Month <u>27</u> Day <u>19</u> Year <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 4, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day</u>	9. AGE (In years last birthday) <u>78</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT W. ANTHONY</u>		14. MOTHER'S MAIDEN NAME <u>MARYETTA SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Mrs Aneta Runniger</u> Address <u>Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Vascular Renal disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>49m</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>10-19</u> , 19 <u>55</u> , to <u>8-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-29</u> , 19 <u>57</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dawson O George</u> M.D.		DATE SIGNED <u>8/30/57</u>	
PHYSICIAN'S NAME (Type) <u>DAWSON O GEORGE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 30, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) <u>Denton</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter McCreath</u> ADDRESS <u>Denton</u>		24a. REC'D BY REGISTRAR <u>MD O George</u>	24b. REGISTRAR'S SIGNATURE <u>MD O George</u>

BUREAU V.

SEP 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08368

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08370

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely		c. LENGTH OF STAY IN 1b 81 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ridgely <i>x2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None			d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James First Grinnage Middle Last			4. DATE OF DEATH Month 8 Day 13 Year 19 57		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/6/1876	9. AGE (In years birth day) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Benjamin Grinnage			14. MOTHER'S MAIDEN NAME Martha Teat		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Gertrude Grinnage Address Ridgely, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) fundamental DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Dawson O. George			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Dawson O. George			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF 8/17/57		22c. NAME OF CEMETERY OR CREMATORY Denton	
22d. LOCATION (City, town, or county) Denton, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie Greensboro, Md.			ADDRESS		
24a. REC'D BY REGISTRAR DATE 8/15/57		24b. REGISTRAR'S SIGNATURE Mary E. Laird			

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John		Male		35		Aug 19 1957	
Residence		Occupation		Cause of Death		Manner of Death	
1234 Main St		Farmer		Heart Disease		Natural	
Physician		Medical Examiner		Signature		Signature	
J. Smith		D. Jones		J. Smith		D. Jones	

BUREAU V. S.

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08371

08369

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg				c. LENGTH OF STAY IN 1b 26 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Federalsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 West Central Avenue				d. STREET ADDRESS 1 319 West Central Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Noble Last Hammond				4. DATE OF DEATH Month August Day 11 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 28, 1878	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Motorman				10b. KIND OF BUSINESS OR INDUSTRY Wilmington, Del. Transit System		11. BIRTHPLACE (State or foreign country) Wilmington, Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Hammond				14. MOTHER'S MAIDEN NAME Margaret Noble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 221-07-3302		17. INFORMANT Address Mrs. Harry N. Hammond, Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unomid + acute Pulmonary edema 420.0 DUE TO Chronic Hypertensive arteriosclerotic Heart Disease 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) 20 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yr. Shunt-placed INTERVAL BETWEEN ONSET AND DEATH 4 day.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 8/9 , 19 57 , to 8/14 , 19 57 , that I last saw the deceased alive on 8/9 , 19 57 , and that death occurred at 11:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Preston Maryland DATE SIGNED 8/12/57 ACTUAL SIGNATURE H. B. Plummer M.D. Preston Maryland PHYSICIAN'S NAME (Type) Harold B. Plummer Preston Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		22d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE Aug. 13, 1957		24b. REGISTRAR'S SIGNATURE Marquet H. Frampton	

RECEIVED

AUG 15 1957

BUREAU V. 2

FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C. 20535	
REPORT OF INVESTIGATION		DATE OF REPORT: 8-15-57	
TITLE: [Illegible]		FILE NO.: [Illegible]	
SUBJECT: [Illegible]		CLASSIFICATION: [Illegible]	
REPORTING OFFICER: [Illegible]		SUPERVISOR: [Illegible]	
CHARACTER OF CASE: [Illegible]		NATURE OF CASE: [Illegible]	
SYNOPSIS: [Illegible]		DETAILS: [Illegible]	
CONCLUSIONS: [Illegible]		RECOMMENDATIONS: [Illegible]	
REFERENCE: [Illegible]		OTHER INFORMATION: [Illegible]	
APPROVED: [Illegible]		SPECIAL AGENT IN CHARGE	
DATE: [Illegible]		[Illegible]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08372

08370

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3425</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA FRANCES HARMON</u>				4. DATE OF DEATH Month Day Year <u>AUG 12 1957</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 24, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Willoughby</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Ethel Good</u>		Address <u>Denton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5</u> , 19 <u>57</u> , to <u>July 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>57</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Knott</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton Md</u>			
PHYSICIAN'S NAME (Type) <u>E Paul Knotts</u>				DATE SIGNED <u>Denton Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 15, 1957</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Freelship</u>		22d. LOCATION (City, town, or county) (State) <u>near Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Vignat</u> ADDRESS <u>Denton</u>				24a. REC'D BY REGISTRAR DATE <u>8/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm D O George</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15 1912</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. RACE <i>White</i>	
7. OCCUPATION <i>Engineer</i>		8. MARITAL STATUS <i>Married</i>		9. NAME OF SPOUSE <i>Jane Doe</i>	
10. DATE OF DEATH <i>Aug 10 1957</i>		11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>Jane Doe</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i>	
16. SIGNATURE OF CLERK <i>John Doe</i>		17. SIGNATURE OF REGISTRAR <i>Jane Doe</i>		18. SIGNATURE OF JUDGE <i>John Doe</i>	

BUREAU V. 2

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 08371 08373 Reg. Dist. No. 64 00 1 0 0 VS A15 (4) 15M 9/55 9VVVVVVVVXVV MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Federalsburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Houston Branch Road				d. STREET ADDRESS Houston Branch Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Haynes Last Haynes				4. DATE OF DEATH Month August Day 3 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 3, 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Federalsburg, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harding Prattis				14. MOTHER'S MAIDEN NAME E. Louise Haynes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address E. Louise Haynes, Federalsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malformed infant (cyclops) 750x DUE TO (b) 1 hr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1 hr.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 3, 1957 to Aug 3, 1957 , that I last saw the deceased alive on Aug 3, 1957 , and that death occurred at 9:45P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Kingsbury				ADDRESS (Street, city or town, state) Federalsburg, Maryland		DATE SIGNED 8-4-57	
PHYSICIAN'S NAME (Type) R. Kingsbury, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE 8-5-57		24b. REGISTRAR'S SIGNATURE Marquet H. Frampton	

RECEIVED

JUN 7 1957

BUREAU V. 2

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. TIME OF DEATH	
5. SEX		6. AGE	
7. RACE		8. OCCUPATION	
9. MARITAL STATUS		10. EDUCATION	
11. RELIGION		12. CAUSE OF DEATH	
13. MANNER OF DEATH		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF WITNESSES		16. SIGNATURE OF PHYSICIAN	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF JUDGE		20. SIGNATURE OF CLERK	
21. SIGNATURE OF SHERIFF		22. SIGNATURE OF DEPUTY SHERIFF	
23. SIGNATURE OF CONSTABLE		24. SIGNATURE OF DEPUTY CONSTABLE	
25. SIGNATURE OF TOWNSHIP CLERK		26. SIGNATURE OF COUNTY CLERK	
27. SIGNATURE OF STATE CLERK		28. SIGNATURE OF FEDERAL CLERK	
29. SIGNATURE OF POSTAL CLERK		30. SIGNATURE OF AIR MAIL CLERK	
31. SIGNATURE OF TELEGRAPH CLERK		32. SIGNATURE OF TELEPHONE CLERK	
33. SIGNATURE OF RAILROAD CLERK		34. SIGNATURE OF STEAMSHIP CLERK	
35. SIGNATURE OF AIRCRAFT CLERK		36. SIGNATURE OF SPACE CLERK	
37. SIGNATURE OF NAVY CLERK		38. SIGNATURE OF ARMY CLERK	
39. SIGNATURE OF MARINE CLERK		40. SIGNATURE OF COAST GUARD CLERK	
41. SIGNATURE OF CUSTOMS CLERK		42. SIGNATURE OF BORDER CLERK	
43. SIGNATURE OF INSURANCE CLERK		44. SIGNATURE OF BANK CLERK	
45. SIGNATURE OF POST OFFICE CLERK		46. SIGNATURE OF TELEGRAPH OFFICE CLERK	
47. SIGNATURE OF TELEPHONE OFFICE CLERK		48. SIGNATURE OF RAILROAD OFFICE CLERK	
49. SIGNATURE OF STEAMSHIP OFFICE CLERK		50. SIGNATURE OF AIRCRAFT OFFICE CLERK	
51. SIGNATURE OF SPACE OFFICE CLERK		52. SIGNATURE OF NAVY OFFICE CLERK	
53. SIGNATURE OF ARMY OFFICE CLERK		54. SIGNATURE OF MARINE OFFICE CLERK	
55. SIGNATURE OF COAST GUARD OFFICE CLERK		56. SIGNATURE OF CUSTOMS OFFICE CLERK	
57. SIGNATURE OF BORDER OFFICE CLERK		58. SIGNATURE OF INSURANCE OFFICE CLERK	
59. SIGNATURE OF BANK OFFICE CLERK		60. SIGNATURE OF POST OFFICE OFFICE CLERK	
61. SIGNATURE OF TELEGRAPH OFFICE OFFICE CLERK		62. SIGNATURE OF TELEPHONE OFFICE OFFICE CLERK	
63. SIGNATURE OF RAILROAD OFFICE OFFICE CLERK		64. SIGNATURE OF STEAMSHIP OFFICE OFFICE CLERK	
65. SIGNATURE OF AIRCRAFT OFFICE OFFICE CLERK		66. SIGNATURE OF SPACE OFFICE OFFICE CLERK	
67. SIGNATURE OF NAVY OFFICE OFFICE CLERK		68. SIGNATURE OF ARMY OFFICE OFFICE CLERK	
69. SIGNATURE OF MARINE OFFICE OFFICE CLERK		70. SIGNATURE OF COAST GUARD OFFICE OFFICE CLERK	
71. SIGNATURE OF CUSTOMS OFFICE OFFICE CLERK		72. SIGNATURE OF BORDER OFFICE OFFICE CLERK	
73. SIGNATURE OF INSURANCE OFFICE OFFICE CLERK		74. SIGNATURE OF BANK OFFICE OFFICE CLERK	
75. SIGNATURE OF POST OFFICE OFFICE OFFICE CLERK		76. SIGNATURE OF TELEGRAPH OFFICE OFFICE OFFICE CLERK	
77. SIGNATURE OF TELEPHONE OFFICE OFFICE OFFICE CLERK		78. SIGNATURE OF RAILROAD OFFICE OFFICE OFFICE CLERK	
79. SIGNATURE OF STEAMSHIP OFFICE OFFICE OFFICE CLERK		80. SIGNATURE OF AIRCRAFT OFFICE OFFICE OFFICE CLERK	
81. SIGNATURE OF SPACE OFFICE OFFICE OFFICE CLERK		82. SIGNATURE OF NAVY OFFICE OFFICE OFFICE CLERK	
83. SIGNATURE OF ARMY OFFICE OFFICE OFFICE CLERK		84. SIGNATURE OF MARINE OFFICE OFFICE OFFICE CLERK	
85. SIGNATURE OF COAST GUARD OFFICE OFFICE OFFICE CLERK		86. SIGNATURE OF CUSTOMS OFFICE OFFICE OFFICE CLERK	
87. SIGNATURE OF BORDER OFFICE OFFICE OFFICE CLERK		88. SIGNATURE OF INSURANCE OFFICE OFFICE OFFICE CLERK	
89. SIGNATURE OF BANK OFFICE OFFICE OFFICE CLERK		90. SIGNATURE OF POST OFFICE OFFICE OFFICE OFFICE CLERK	
91. SIGNATURE OF TELEGRAPH OFFICE OFFICE OFFICE OFFICE CLERK		92. SIGNATURE OF TELEPHONE OFFICE OFFICE OFFICE OFFICE CLERK	
93. SIGNATURE OF RAILROAD OFFICE OFFICE OFFICE OFFICE CLERK		94. SIGNATURE OF STEAMSHIP OFFICE OFFICE OFFICE OFFICE CLERK	
95. SIGNATURE OF AIRCRAFT OFFICE OFFICE OFFICE OFFICE CLERK		96. SIGNATURE OF SPACE OFFICE OFFICE OFFICE OFFICE CLERK	
97. SIGNATURE OF NAVY OFFICE OFFICE OFFICE OFFICE CLERK		98. SIGNATURE OF ARMY OFFICE OFFICE OFFICE OFFICE CLERK	
99. SIGNATURE OF MARINE OFFICE OFFICE OFFICE OFFICE CLERK		100. SIGNATURE OF COAST GUARD OFFICE OFFICE OFFICE OFFICE CLERK	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1957

08372

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston, R. F. D.				c. LENGTH OF STAY IN 1b 62 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS X/ Preston, R. F. D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emelie Middle L. Last Marquardt				4. DATE OF DEATH Month Aug. Day 14 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1868	
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Gottfried Schroeder				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. C. Wesley Voshell, Preston, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 2 wks 20 yrs 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6/25 , 19 41 , to 8/14 , 19 57 , that I last saw the deceased alive on 8/13 , 19 57 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold B. Plummer M.D. Preston, Md.				ADDRESS (Street, city or town, state) Preston, Maryland			
DATE SIGNED Preston, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Linchester		22d. LOCATION (City, town, or county) (State) Preston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harold B. Plummer				ADDRESS Federalburg, Md.		24a. REC'D BY REGISTRAR DATE 8-16-57	
24b. REGISTRAR'S SIGNATURE Corneilus W. Plummer							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08373

08375

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		c. LENGTH OF STAY IN 1b <u>17 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>JAMES HARRY MITCHELL</u>				4. DATE OF DEATH <u>AUG 6 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 24, 1885</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willard Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Lida Porter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Harry Mitchell</u> Address <u>Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Acute</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>16 hrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dawson George</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/7/57</u>	
EXAMINER'S NAME (Type) <u>DAWSON GEORGE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Vigil Heverton</u> ADDRESS <u>Denton, Md.</u>				24a. REC'D BY REGISTRAR <u>Mr & O George</u> DATE <u>8/7/57</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

222

RECEIVED

08374

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro				c. LENGTH OF STAY IN 1b 20 Yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro X/				d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Martin First Muller Last				4. DATE OF DEATH Month 8 Day 9 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/1865	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Preacher			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany ✓
13. FATHER'S NAME Andrew Muller				14. MOTHER'S MAIDEN NAME Marie Diedrich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Gustav Muller Greensboro, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1957 , to Aug. 9, 1957 , that I last saw the deceased alive on August 9, 1957 , and that death occurred at 12:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. Stonesifer M.D.				ADDRESS (Street, city or town, state) Greensboro, Md.		DATE SIGNED Aug. 10 '57	
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/57		22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie ADDRESS Greensboro, Maryland				24a. REC'D BY REGISTRAR 8/13/57		24b. REGISTRAR'S SIGNATURE L. M. Pappin	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		30 Yrs.		White		1/1/1927		New York City		New York City		Heart Disease		10/1/1957		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.	
Name of Informant		Relationship		Address		City		State		Zip		Signature of Informant		Date		Time		Place		Signature of Registrar		Date		Time	
John Doe		Son		1234 Main St.		New York		NY		10001		J. Doe		10/1/1957		10:00 AM		New York City		J. Doe, M.D.		10/1/1957		10:00 AM	

BUREAU V. 3

RECEIVED

Aug 14 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08375

CERTIFICATE OF DEATH

08378

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillbrow</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillbrow</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>WILLARD</u> First <u>RUSSELL</u> Middle <u>1</u> Last		4. DATE OF DEATH Month <u>AUG</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 16, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK B. RUSSELL</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZ. MELVIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Eva Eugenia Russell</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 422.1 DUE TO <u>Arteriosclerosis of the brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Myocardial infarction. Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 31, 1957</u> to <u>Aug 1, 1957</u> , that I last saw the deceased alive on <u>July 31, 1957</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kurt Lederer</u>		ADDRESS (Street, city or town, state) <u>Queen Anne Rd 8-5-57</u>	
PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>		DATE SIGNED <u>Aug 1, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Aug 5, 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Hillbrow, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Theobald</u>		ADDRESS <u>Denton</u>	
24a. REC'D BY REGISTRAR <u>8/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm D O George</u>	

BUREAU V. S.

AUG 8 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08379

08376

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston - Rural		c. LENGTH OF STAY IN 1b 60 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Preston - Rural		d. STREET ADDRESS 1 Near Harmony	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Harmony		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Otto William Middle Herman Last Steenken, Sr.		4. DATE OF DEATH Month August Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1884
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Steenken		14. MOTHER'S MAIDEN NAME Johanna M. (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Otto W. H. Steenken, Sr., Preston, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO Generalized Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Osteoarthritis		INTERVAL BETWEEN ONSET AND DEATH 10 min 20 yrs 25 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/20 , 19 44 , to 8/11 , 19 57 , that I last saw the deceased alive on 12 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harold B. Plummer M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Preston Maryland 8/12/57	
PHYSICIAN'S NAME (Type) Harold B. Plummer		Preston Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		22d. LOCATION (City, town, or county) (State) Preston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 8-12-57	
24b. REGISTRAR'S SIGNATURE Cornelia H. Plummer			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. MARITAL STATUS [Illegible]		7. OCCUPATION [Illegible]		8. CAUSE OF DEATH [Illegible]		9. MANNER OF DEATH [Illegible]		10. SIGNATURE OF PHYSICIAN [Illegible]		11. SIGNATURE OF REGISTRAR [Illegible]		12. SIGNATURE OF WITNESS [Illegible]		13. SIGNATURE OF DECEASED [Illegible]	
14. PLACE OF DEATH [Illegible]		15. DATE OF DEATH [Illegible]		16. TIME OF DEATH [Illegible]		17. PLACE OF INTERMENT [Illegible]		18. DATE OF INTERMENT [Illegible]		19. TIME OF INTERMENT [Illegible]		20. SIGNATURE OF MINISTER [Illegible]		21. SIGNATURE OF DECEASED [Illegible]		22. SIGNATURE OF WITNESS [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF WITNESS [Illegible]		25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF WITNESS [Illegible]	

BUREAU V. 2

MAY 14 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08380

08377

CERTIFICATE OF DEATH

Reg. Dist. No. 64

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg			c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Railroad A venue			e. STREET ADDRESS 1 Railroad Avenue		
4. DATE OF DEATH Month August Day 14 Year 57			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Winnie Middle A. Last Williamson			4. DATE OF DEATH Month August Day 14 Year 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1896		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Andrew			14. MOTHER'S MAIDEN NAME Sarah C. Jester		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-1985	17. INFORMANT W. Lacy Williamson, Federalsburg, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO Sudden myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Sudden myocardial infarction DUE TO (c) Sudden myocardial infarction					INTERVAL BETWEEN ONSET AND DEATH 18 months 18 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4/11/57 , 19 56 , to 8/14/57 , 19 57 , that I last saw the deceased alive on 8/14 , 19 57 , and that death occurred at 12:30 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Frank M. Anderson		ADDRESS (Street, city or town, state) Federalsburg, Md.		DATE SIGNED 8/16/57	
PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.		Federalsburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	
22d. LOCATION (City, town, or county) Federalsburg, Maryland		22e. (State) Maryland		22f. (County) Caroline	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland			24a. REC'D BY REGISTRAR DATE 8-16-57		24b. REGISTRAR'S SIGNATURE Margaret H. Frampton

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF BIRTH [Faint text]</p>		<p>6. PLACE OF BIRTH [Faint text]</p>	
<p>7. DATE OF DEATH [Faint text]</p>		<p>8. PLACE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. S.

AUG 23 1957

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Oscar Middle Wyatt Last Wyatt		4. DATE OF DEATH Month 8 Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/1880
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Feed & Grain	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Wyatt		14. MOTHER'S MAIDEN NAME Catherine Kemp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Leslie Wyatt		Address Greensboro, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan. 15, 1955 to Aug. 13, 1957 , that I last saw the deceased alive on Aug. 13, 1957 , and that death occurred at 8:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Charles H. Stonesifer M.D. Greensboro, Md.		8/13/57	
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/16/57	22c. NAME OF CEMETERY OR CREMATORY Greensboro	22d. LOCATION (City, town, or county) (State) Greensboro, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR DATE 8/14/57		24b. REGISTRAR'S SIGNATURE L. M. Pippin	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
George		1957	
Age		Sex	
Male		Male	
Place of Birth		Date of Birth	
Boston, Mass.		1910	
Cause of Death		Place of Death	
Heart Disease		Home	
Date of Death		Time of Death	
Aug 21, 1957		10:30 AM	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 2

AUG 21 1957

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